Annual Adult Health Questionnaire

Please complete (or update) as thoroughly as possible, using a pencil.

Medical History

Do you now or have you ever had any of the following illnesses:

Nutritionally Related

__Anemia
__Diabetes
__Difficulty chewing, swallowing, or preparing food
__Eating disorder
__Ever been told/are malnourished
__High Blood Pressure
__High Cholesterol/Triglycerides
__History of radiation/chemotherapy
__Gastrointestinal disease
__Gout
__Kidney problems
__Osteoporosis
__*Strict* vegetarian (no meat)
__Unintentional loss/gain ≥ 10lb over the last 6 months

__Cancer
__Breast
__Cervical
__Colorectal
__Lung
__Skin
__Prostate
__Uterine
Other: _____
_____

__Arthritis
__Osteoarthritis
__Rheumatoid
__Allergies (Seasonal, Etc.)
__Asthma
__Bleeding problem
__Blood clots
__Blood transfusion
__COPD
__Fracture _____
__Headache
__Migraine __ Tension
__Heart disease
__Coronary Heart Disease
__Heart Attack – age ____
__Congestive Heart Failure
__Heart valve problems
__Hepatitis/Jaundice
__Irregular menstrual periods
__Menopause – when _____
__Psychiatric
__Depression
__Anxiety
__Panic Attacks
Other:_____
__Seizures/Epilepsy
__Sexually transmitted disease
__Stroke
__Thyroid (high/low)
__Tuberculosis (positive TB test)
Other:_____
_____
_____
_____

Surgeries or Hospitalizations

When

Social History

Do you now or have you ever:

__Alcohol – amount _____
__ in the past – how long ago ____
__Caffeine
__Tattoo
__Tobacco – amount _____
__ in the past – how long ago ____
__ Smokeless tobacco
__ in the past – how long ago ____

Family History

Anyone in your family have:

	Who
__Diabetes	_____
__Cancer	_____
__Breast	_____
__Colorectal	_____
__Leukemia	_____
__Ovarian	_____
__Prostate	_____
__Thyroid	_____
__Uterine	_____
Other: _____	_____
__Heart disease	_____
__Coronary Heart Disease	_____
__Heart Attack – age ____	_____
__Congestive Heart Failure	_____
__High Blood Pressure	_____
__High Cholesterol	_____
__Stroke	_____
__Thyroid (high/low)	_____
Other:_____	_____
_____	_____

Key: M, F, S(ibling), MGM, MGF, PGM, PGF, MA, MU, PA, PU

Learning Needs Assessment

1. Do you have any medical problems that make it difficult for you to understand medical information or instructions? **Y / N**
2. Do you have any religious or cultural beliefs that may interfere with your medical care? **Y / N**
3. Do you feel your emotional state (mood) may interfere with your medical care? **Y / N**
4. Do financial problems interfere with your ability to obtain or continue medical care or treatments? **Y / N**
5. Do you have any trouble reading or understanding medical instructions or materials given to you? **Y /N**
6. In which way do you learn best? *__verbal __written handout __individual __hands-on __video __group*

Patient Identification: *(For typed or written entries give: Name – last, first, middle; ID No or SSN; Sex; DOB; Rank/Grade.)*

Allergies

Drug

Other

Medications

Herbs/Supplements/Vitamins

When was your last:	**Date**
___ TB test	_____
___ Tetanus booster	_____
___ Flu vaccine	_____
___ Pneumococcal vaccine	_____
___ Pap Smear	_____
___ Mammogram	_____
___ Prostate/digital rectal exam/PSA	_____
___ Testicular exam	_____
___ Colorectal cancer screening	_____
___ Skin cancer exam	_____
___ Blood pressure screen	_____
___ Cholesterol screen	_____
___ Eye exam	_____
___ Hearing screening	_____
___ Dental exam	_____

Counseling

*In the **past 12 months** have you been counseled regarding:*

__ Exercise
__ Dental
__ Injury prevention
__ Nutrition/Folate replacement
__ Cancer prevention
__ Safe Sex
__ Family Planning
__ Review of medications
__ Mental Health
__ Occupational stress
__ Problems at home
__ Hormone replacement
__ Calcium supplementation
__ Tobacco use
__ Alcohol use
__ Drug abuse
__ Travel history
__ Occupational exposure (toxins/noise/repetitive motion)

Personal Health Maintenance

Do you perform your own exams:
__ Breast __ Testicular __ Skin

Do you have an Advanced Directive (Living Will)?

__Yes (last updated:_____) __No
Is a copy your chart? __Yes __No

If you have *diabetes*	**Date**
When was your last:	
__ A1C	_____
__ Fasting lipid (cholesterol) panel	_____
__ Dilated eye exam	_____
__ Urine protein	_____
__ Foot exam	_____
__ Nutrition consult	_____

If you have *high blood pressure*

When was your last electrocardiogram? _____
Do you check your pressure at home? __Y __N
Is your average pressure < 140/90?
__Yes __No
If you have diabetes, is your pressure <130/85?
__Yes __No
When was you last urinalysis? _____

If you have *high cholesterol*	**Date**
When was your last:	
__ Fasting lipid (cholesterol) panel	_____
__ Liver enzymes checked	_____
__ Nutrition consult	_____

If you have *asthma*	**Date**
When was your last:	
__Peak flow meter	_____
__Spirometry	_____

How many attacks during the past year? _____
How many ER visits during past year? _____
Have you ever been hospitalized? __Yes __No

During the past *2 weeks* have you…,	**Are your children/spouse:**
Been feeling down, depressed or hopeless? __Yes __No	EFMP Screened __Y __N
Lost interest or pleasure in things that you used to enjoy? __Yes __No	EFMP Enrolled __Y __N

Patient Signature: _____ Provider Signature: _____ Date: _____
Patient Signature: _____ Provider Signature: _____ Date: _____
Patient Signature: _____ Provider Signature: _____ Date: _____
Patient Signature: _____ Provider Signature: _____ Date: _____
Patient Signature: _____ Provider Signature: _____ Date: _____